SERFF Tracking Number:	*FDLA-125654497*	*State:*	*Arkansas*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*39072*
Company Tracking Number:	*AH-5/21-9551308AR*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Evidence of Insurability Application*		
Project Name/Number:	*Evidence of Insurability Application/9-551-308*		

Filing at a Glance

Company: Fort Dearborn Life Insurance Company

Product Name: Evidence of Insurability Application	SERFF Tr Num: FDLA-125654497	State: ArkansasLH
TOI: L04G Group Life - Term	SERFF Status: Closed	State Tr Num: 39072
Sub-TOI: L04G.500 Other	Co Tr Num: AH-5/21-9551308AR	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Author: Antionette Hill	Disposition Date: 05/27/2008
	Date Submitted: 05/21/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Evidence of Insurability Application	Status of Filing in Domicile:
Project Number: 9-551-308	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Arkansas does not require domicile state approval.
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 05/27/2008	
State Status Changed: 05/27/2008	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

We are submitting for your review and approval our Evidence of Insurability application. This is a new form; and, it will replace Evidence of Insurability application, form number 9-551-707, approved by your Department on November 8, 2007. The SERFF tracking number for the previously approved form is FDLA-125329406. The form will be used with our previously, and subsequently, approved group life and disability products.

The previously approved form has not been used in your state. The revision to the form is in Part 3 - questions 8 and 9

have been added. In all other respects, the form remains unchanged.

This application may, at some time in the future, be converted to an electronic document. Such adaptation may slightly alter the appearance of the document, but we assure you that the content will not change and its readability compliance will not be affected. Also, at some point, we anticipate utilizing electronic signatures in a form compliant with your state's laws and regulations.

Company and Contact

Filing Contact Information

Antionette Hill, Advanced Contract Specialist	Antionette_Hill@fdlic.com
1020 31st Street	(630) 824-6064 [Phone]
Downers Grove, IL 60515-5591	(630) 824-5428[FAX]

Filing Company Information

Fort Dearborn Life Insurance Company	CoCode: 71129	State of Domicile: Illinois
1020 31st Street	Group Code: 917	Company Type: Life and Health
Downers Grove, IL 60515-5591	Group Name:	State ID Number:
(800) 633-3696 ext. [Phone]	FEIN Number: 36-2598882	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	IL fee is $50.00 per form
	1 form X $50.00 = $50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Fort Dearborn Life Insurance Company	$50.00	05/21/2008	20438752

SERFF Tracking Number:	*FDLA-125654497*	*State:*	*Arkansas*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*39072*
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TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Evidence of Insurability Application*		
Project Name/Number:	*Evidence of Insurability Application/9-551-308*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	05/27/2008	05/27/2008

SERFF Tracking Number:	*FDLA-125654497*	*State:*	*Arkansas*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*39072*
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Product Name:	*Evidence of Insurability Application*		
Project Name/Number:	*Evidence of Insurability Application/9-551-308*		

Disposition

Disposition Date: 05/27/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FDLA-125654497*	*State:*	*Arkansas*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*39072*
Company Tracking Number:	*AH-5/21-9551308AR*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Evidence of Insurability Application*		
Project Name/Number:	*Evidence of Insurability Application/9-551-308*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Form	Evidence of Insurability Application		Yes

SERFF Tracking Number:	*FDLA-125654497*	*State:*	*Arkansas*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*39072*
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TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Evidence of Insurability Application*		
Project Name/Number:	*Evidence of Insurability Application/9-551-308*		

Form Schedule

Lead Form Number: 9-551-308

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	9-551-308	Application/ Enrollment Form	Evidence of Insurability Application	Initial			9-551-308 - Evidence of Insurability.pdf

FORT DEARBORN LIFE
Insurance Company®
Chicago, Illinois

Evidence of Insurability (EOI)

Administrative Offices: **Downers Grove, Illinois I Cleveland, Ohio I Dallas, Texas**

PART 1: TO BE COMPLETED BY GROUP ADMINISTRATOR/EMPLOYER (Please Print and submit with copy of employee enrollment form)

Group Number _____

Group Name and Address

Group Contact _____
(Print Name)

Group Contact _____
(Print Title)

Telephone (_____) _____

Fax (_____) _____

Reason for EOI:
☐ Amount over Guarantee Issue
☐ Late Enrollment
☐ Other _____

If New Hire, Indicate Eligibility Waiting Period
_____

Policy Anniversary Date
_____

FOR FDL USE ONLY

EMPLOYEE	SPOUSE	CHILD(REN)
☐ Approved ☐ Declined ☐ Closed ☐ Smoker ☐ Nonsmoker	☐ Approved ☐ Declined ☐ Closed ☐ Smoker ☐ Nonsmoker	☐ Approved ☐ Declined ☐ Closed Amount Approved $_____ Effective Date*
GI ☐ No ☐ Yes $_____	GI ☐ No ☐ Yes $_____	Reviewed by & date _____
Amount Approved $_____ Effective Date* Reviewed by & date _____	Amount Approved $_____ Effective Date* Reviewed by & date _____	State Code _____ Agency (CB)(TPA) _____ ☐ SAWEB ☐ Self-Admin ☐ Direct Bill _____

* The effective date of coverage is the date the application is approved. Premium is due the first of the month following the approval date. **Do not deduct premiums for any coverage subject to evidence of insurability until you receive FDL's final confirmation of approval.**

PART 2: TO BE COMPLETED BY EMPLOYEE - This section contains essential information and leaving any item blank will cause a delay in processing your insurance request.

EMPLOYEE

Name Last	First	M.I.	Date of Birth / /	Age	Sex ☐ M ☐ F	State of Birth

Home Mailing Address - Street	City	State	Zip	Work Telephone ( )	Home Telephone ( )

Social Security #	Height ft. in.	Weight lbs.

SPOUSE - DO NOT complete spouse information unless you are applying for dependent spouse coverage.

Name Last	First	M.I.	Date of Birth / /	Age	Sex ☐ M ☐ F	State of Birth

Social Security #	Height ft. in.	Weight lbs.

CHILD(REN) - DO NOT complete this section unless you are applying for dependent child(ren) life insurance which is subject to satisfactory evidence of insurability (for example, a late enrollment.) *Evidence of insurability is not required for voluntary dependent child term life coverage.*

Dependent Child Full Name	SS#	Date of Birth	Age	Sex	Ht & Wt
				☐ M ☐ F	
				☐ M ☐ F	
				☐ M ☐ F	

YOU MUST COMPLETE ALL PAGES OF THIS APPLICATION IN ORDER TO BE CONSIDERED FOR COVERAGE.
Retain a copy of this application for your records.

Part 3: Health Information (Answer all questions fully, accurately, and truthfully for any person applying for coverage.)

Check either **"Yes"** or **"No"** to each question and **circle the specific condition(s). Details to all "yes" answers must be provided below. Failure to provide full information or providing false information may result in denial of benefits and/or possible investigation for fraud.**	**Employee** Yes	No	**Spouse** Yes	No	**Child(ren)** Yes	No
1. Has any person applying for coverage been seen, treated, advised or received services from any health provider <u>in the last 12 months</u>, including routine physicals?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
2. Within the last 7 years, **has any person applying for coverage had symptoms, been diagnosed with and/or received treatment by/from a member of the health profession for any of the conditions listed in the questions below?**						
a. High blood pressure, heart attack, chest pain, shortness of breath, irregular heartbeat, murmur, coronary artery disease, heart surgery (catheterization/ angioplasty/bypass, etc.), or any other disease or disorder of the heart or circulatory system?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
b. Enlarged glands, thyroid disorder, diabetes, abnormal glucose level, hepatitis, cirrhosis, abnormal liver studies, hernia, ulcer, colitis or any other disease or disorder of the liver, endocrine, or digestive system?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
c. Alcohol and/or drug abuse/addiction/treatment, depression, anxiety, bipolar, ADD/ADHD, anorexia, bulimia or any other mental/nervous/behavioral disorder?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
d. Asthma, emphysema, tuberculosis, pneumonia, COPD, sleep apnea, or any other disease or disorder of the throat, lungs, or respiratory tract?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
e. Prostate, uterus/tubes/ovaries, endometriosis, cystitis, kidney stone, renal failure, sexually transmitted diseases, any disorder of the kidneys/bladder/ urinary tract, breast lumps/changes/biopsies, abnormal test results or any other male/female disorder?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
f. Cancer, tumor, cyst, moles, polyps, growth or any skin disorder (indicate location and if benign/malignant)?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
g. Stroke, paralysis, convulsions, seizures, epilepsy, fainting, headaches, dizziness, or any other disease or disorder of the nervous system?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
h. Arthritis, gout, rheumatism, neck or back strain/sprain/injury, deformity, loss of limb, or any other disease or disorder of the back, spine, muscles, bones or joints?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
3. Has any person applying for coverage been diagnosed with or received treatment for an immune system disorder, including AIDS-Related Complex (ARC), Acquired Immune Deficiency Syndrome (AIDS), or tested positive for antibodies to the AIDS (Human Immunodeficiency) Virus?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
4. Does any person applying for coverage currently take medication (prescription or otherwise), been prescribed medication, or has any person done so <u>in the last 6 months</u>?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
5. <u>Within the last 2 years</u>, has any person applying for coverage had a physical disability, surgery, or been confined to a hospital, skilled nursing or rehabilitation facility, undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, MRI, CAT Scans, PET or CT Scans, biopsies, blood or urine tests; or had any medical advice, examination, consultation or treatment; and/or been advised of future surgery, treatment, therapy, hospitalization, testing or evaluation to be performed, not mentioned in questions 1 through 3?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
6. Is any person applying for coverage <u>currently</u> pregnant? If **"Yes"**, indicate anticipated delivery date _____. **Provide details of any current/ prior complications on Page 3.**	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
7. Has any person applying for coverage *EVER HAD* symptoms, been diagnosed with, and/or received treatment from a member of the health profession for **ANY HEALTH CONDITION** other than those conditions listed above?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No

Employee Name _____ Social Security #_____

Part 3 (Continued): Health Information (Answer all questions fully, accurately, and truthfully for any person applying for coverage.)

	Employee Yes No	Spouse Yes No	Child(ren) Yes No
8. Has any person applying for coverage used cigarettes or other tobacco products in the last 2 years?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
9. Has any person applying for coverage been rated, declined, postponed or limited in any way for life, health, accident or disability insurance?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No

PART 4: Provide details of all 'YES' answers given to questions in PART 3. – If additional space is required, attach a separate signed and dated sheet.

#	Person	Type of Condition	Dates	Hospitalized Yes No	Surgery Yes No	Treatment/ Medication	Current Meds/ Remaining Problems	Physician's Name, Address & Phone#

Employee Name _____ Social Security #_____

No premiums may be deducted on amounts subject to evidence of insurability until a final decision regarding approval of coverage is received by your employer from Fort Dearborn Life.

WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. (Not enforceable in Oregon or Virginia.)

AGREEMENTS AND AUTHORIZATION: I, the undersigned applicant(s), have read and agree that the above statements are complete, true and correctly recorded to the best of my knowledge and belief. Further, I understand Fort Dearborn Life Insurance Company® (FDL) shall not be liable for any claim arising prior to the date of approval of this application at FDL's Home Office.

To determine my eligibility for the coverages applied for, I authorize any medical professional, hospital, clinic or other medical or medically-related facility, medical provider, the MIB Group, Inc., or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to FDL's underwriting department or its authorized representative(s) my medical records, or that of my children, including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases.

I further authorize FDL to disclose the information obtained in the consideration of my application for insurance to its reinsurers and the MIB Group, Inc. a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

This authorization shall expire 24 months from the date it is signed. I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by FDL prior to receipt of the revocation;
- Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the HIPAA Privacy Rule;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy of this authorization shall be as valid as the original;
- I have received a Disclosure Statement; and
- Coverage will not become effective until FDL approves my application, provided that I am actively at work on that day.

I as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of this authorization from FDL.

If my answers on this application are incorrect or untrue, or if I refuse to sign this authorization, FDL has the right to deny benefits or rescind my coverage or that of my dependents, if applicable.

_____ _____
Signature of Employee Date

_____ _____
Signature of Spouse (if requesting insurance) Date

_____ _____
Signature of Dependent Child (if to be insured and of age of majority) Date

FORT DEARBORN LIFE
Insurance Company®
Chicago, Illinois

Fraud Notices

Administrative Offices: **Downers Grove, Illinois I Cleveland, Ohio I Dallas, Texas**

The laws of some states require us to furnish you with the following notice:

Arizona & New Jersey - Claims

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Arkansas & Massachusetts

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware, Idaho & Oklahoma

Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

District of Columbia & Virginia

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Louisiana & New Mexico

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Maryland

Any person who knowingly and willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey - Applications

Any person who knowingly files false or misleading information on an application for insurance coverage is subject to criminal and civil penalties.

Texas

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Washington

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All Other States

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. (not enforceable in OR)

SERFF Tracking Number:	*FDLA-125654497*	*State:*	*Arkansas*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*39072*
Company Tracking Number:	*AH-5/21-9551308AR*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Evidence of Insurability Application*		
Project Name/Number:	*Evidence of Insurability Application/9-551-308*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FDLA-125654497*	*State:*	*Arkansas*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*39072*
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Product Name:	*Evidence of Insurability Application*		
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Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 05/19/2008

Comments:

Attachment:

ARComplianceCert.pdf

Review Status:

Bypassed -Name: Application 05/19/2008

Bypass Reason: A policy is not being submitted for review and approval; therefore, this requirement does not apply.

Comments:

FORT DEARBORN LIFE
Insurance Company

1020 31st Street • Downers Grove, Illinois 60515-5591 • (800) 633-3696 • Fax (630) 824-5428

NAIC #917-71129
FEIN # 36-2598882

STATE OF ARKANSAS
DEPARTMENT OF INSURANCE

CERTIFICATION OF COMPLIANCE

I, Victoria E. Fimea, Vice Present, General Counsel and Secretary of Fort Dearborn Life Insurance Company, hereby certify that, to the best of my knowledge, this submission meets the provisions of Rule & Regulation 19, Rule & Regulation 49, ACA 23-80-206 and ACA 23-79-138, as well as all applicable requirements of the Arkansas Department of Insurance.

Victoria E. Fimea
Vice Present, General Counsel and Secretary

May 20, 2008
Date